CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE
RESPIRATORY CARE PRACTICE ADVISORY COUNCIL

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR A LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER
INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Requirements for *All* Applications

These requirements pertain to ***all*** applications ***– including both new applications and re-applications*** – for Delaware licensure.

☐ Submit completed, signed and notarized application form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.
- Forms that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose processing fee by check or money order made payable to "State of Delaware."
- Applications submitted without this processing fee will be rejected.

☐ If you now hold, or have *ever* held, a Respiratory Care Practitioner license in any jurisdiction other than Delaware, arrange for the Council office to receive a *Verification of Respiratory Care Practitioner License* form from *each* jurisdiction where you have held a license.
- Before forwarding the form, check whether the jurisdiction requires a fee.
- The Council office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
- Internet or faxed verifications will not be accepted.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

Additional Requirements for Applications *Other Than* Re-Applications

These requirements pertain to all applications for Delaware licensure ***other than re-applications*****.** If you are re-applying for Delaware licensure that lapsed, see the **Additional Requirements for Re-Applications** section below.

☐ Submit an 8" X 11 1/2" copy of your Respiratory Care Practitioner diploma.

☐ Arrange for the Council office to receive a *Verification of Respiratory Care Practitioner Education* form from *each* program you attended.
- The Council office must receive the completed form *directly* from the school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ Submit an 8 1/2" x 11" copy of your National Certifying Certificate.

☐ Arrange for the Council office to receive a credential verification letter to be sent directly from the National Board of Respiratory Care (NBRC) to the Council office.
- To request verification, follow the instructions on the NBRC website at Credentialed Practitioners.

☐ If you answer "yes" to any questions in the DISCLOSURES section, you must submit a separate signed statement to fully explain your answer.

Additional Requirements for Re-Applications

These additional requirements apply *only if* you are re-applying for Delaware licensure that you previously held but which can no longer be renewed because it lapsed over three years ago. What you are required to submit depends on whether you have been actively practicing respiratory care outside Delaware in the three years before your re-application.

IF you have…	THEN…	AND you must submit proof that you…
not actively practiced respiratory care for the past three years	submit documentation from the NBRC that you have passed the NBRC Entry Exam during the two years before your re-application	completed 20 hours of continuing education in the two years before your re-application.
actively practiced respiratory care for the past three years	enter information about your active practice on the application.	

- For information on acceptable continuing education, see Section 8.0 of the Respiratory Practice Advisory Council Rules and Regulations.

Temporary Licensure

The temporary permit allows you to practice until the Respiratory Care Practice Advisory Council (Council) reviews your application and your permanent license is issued. A temporary permit is valid for 90 days and cannot be renewed.

You may be issued a temporary permit when the Council office has received **all** the required documentation listed above and determined you meet the licensure requirements.

To apply for a temporary permit…

☐ Answer "yes" to Question 2 on the application form.

☐ Enclose the temporary license fee by check or money order made payable to "State of Delaware."
- This fee is *in addition to* the processing fee for your application. However, you may combine the fees in one check or money order.

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TYPE OF APPLICATION

1. Select the type of Respiratory Care Practitioner (RCP) application you are filing (check one):

   ☐ Application – I have never been licensed as an RCP in Delaware and am applying for a new Delaware license.

   ☐ Re-Application – I previously held a Delaware RCP license that has been lapsed over three years and is no longer renewable. My license number was: **C9 -** _____.

2. Are you also applying for a temporary license? Yes ☐ No ☐

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: _____ _____ _____
   Last First Middle

4. Other Names Used: _____ _____ _____

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   Home Work

7. Date of Birth (month/day/year): _____

8. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: _____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

RESPIRATORY CARE EDUCATION & CERTIFICATION – Applicants ***by re-application*** may skip this section.

9. Enter complete information about your respiratory care education.

SCHOOL NAME	LOCATION	DATES ATTENDED	DEGREE RECEIVED

Submit an 8 1/2" X 11" copy of your respiratory care program diploma and arrange for the Council office to receive a *Verification of Respiratory Care Education* form *directly* from *each* school you listed.

10. Have you ever been deemed ineligible to sit for the NBRC Entry Level Exam for any reason? Yes ☐ No ☐ If yes, explain: _____

11. Have you taken and passed the NBRC Entry Level Exam? Yes ☐ No ☐
    - If yes, enter the date you sat for the exam: _____
    - If no, enter the date of the exam for which you have registered: _____

12. Are you NBRC certified as a Respiratory Care Practitioner? Yes ☐ No ☐

    Submit an 8 1/2" x 11" copy of your National Certifying Certificate. Also, arrange for the Council office to receive a credential verification letter sent *directly* from the NBRC to the Council office.

LICENSURE HISTORY – *All* applicants complete this section.

13. Have you ever been denied a license or a registration to practice as a Respiratory Care Practitioner? Yes ☐ No ☐ If yes, explain: _____
    _____

14. Have you ever held a Respiratory Care Practitioner license in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, list *each* jurisdiction where you now hold, or have *ever* held, a respiratory care practitioner license.

JURISDICTION	LICENSE NUMBER	EXPIRATION DATE

Arrange for the Council office to receive a *Verification of Respiratory Care Practitioner License* form from *each* jurisdiction you listed.

PRACTICE AND CONTINUING EDUCATION – *Only* applicants ***by re-application*** complete this section.

15. Have you completed 20 hours of continuing education in the two years before re-applying? Yes ☐ No ☐

    Submit proof of completing at least 20 hours of acceptable continuing education in the past two years.

16. Have you actively practiced respiratory care ***for the past three years***? Yes ☐ No ☐
    - If no, continue with the next question.
    - If yes, enter the following information about your practice over the past three years and then skip to the DISCLOSURES section.

EMPLOYER	LOCATION (City & State)	EMPLOYMENT DATES	
		From (mm/yyyy)	To (mm/yyyy)

17. Have you re-taken and passed the NBRC Entry Level Exam ***in the past two years***? Yes ☐ No ☐
    - If yes, enter the date you sat for the exam: _____
    - If no, enter the date of the exam for which you have registered: _____

    Arrange for the Council office to receive a credential verification letter sent *directly* from the NBRC to the Council office.

DISCLOSURES – *All* applicants complete this section.

If you answer "yes" to any question in this section, submit a signed statement fully explaining your answer. The statement should specify where and when the incident occurred, the issues involved and any further information you wish to provide.

18. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

    Arrange for the Council office to receive state and federal criminal background checks.

19. Have you ever been the subject of any disciplinary action (formal or informal) by a healthcare facility or any entity governing respiratory care licensure or is any such action pending against you? Yes ☐ No ☐

20. Within the past two years, have you had a physical or mental disability which could reasonably be thought to interfere with your practice as a respiratory care practitioner, including use or abuse of dangerous or addicting substances? Yes ☐ No ☐

21. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ☐ No ☐

To assure consideration of your license application at the next meeting of the Respiratory Care Practice Advisory Council meeting, the Council office must receive all of these items no later than 4:30 PM ten full working days before the Council's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is complete, please allow 4-8 weeks to receive your permanent license.

AFFIDAVIT

I swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; that I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement. I further understand that by filing this application, I authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in Section 6.3 of the Regulations of the Delaware Respiratory Care Practice Advisory Council and to determine that I am physically and mentally capable of engaging in the practice of respiratory care with safety to the public. I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Respiratory Care Practice Advisory Council any such information, including document, records regarding charges or complaints filed against me, formal or informal, pending or closed, other pertinent data and to permit the Delaware Respiratory Care Practice Advisory Council or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd. Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State and Federal criminal checks. As fees are subject to change, contact the agency where you plan to submit your forms for current fees. Cash, money orders and credit cards other than American Express are accepted. *Personal checks are not accepted.*

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE COUNCIL OFFICE

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- ☐ Adult Entertainment
- ☐ Deadly Weapons Dealer
- ☐ Dental
- ☐ Medical
- ☐ Nursing
- ☐ Nursing Home Administrator
- ☐ Pharmacy
- ☐ Texas Hold'em Dealer
- ☐ Other _____

ENTER FULL CURRENT NAME:

_____ _____ _____ _____
Last Name | First Name | Middle Initial | Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 11/2009

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VERIFICATION OF RESPIRATORY CARE PRACTITIONER LICENSE

Send a form to *each* jurisdiction (other than Delaware) where you have ever held a license to practice as a Respiratory Care Practitioner.

Licensing Authority:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for licensure as a Respiratory Care Practitioner in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Respiratory Care Practice Advisory Council.** **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/U.S. Territory of _____ License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION **AFFIX** **OFFICIAL** **SEAL HERE**	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Council office at the address above.**

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VERIFICATION OF RESPIRATORY CARE PRACTITIONER EDUCATION

Respiratory Care Practitioner applicants should send this form to *each* program attended.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Birth Date:_____ Other Name(s) Used: _____ **I am applying for licensure as a Respiratory Care Practitioner in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form.** **Applicant Signature:** _____ Date: _____
This section to be completed by Institution.	1. Enter the dates the applicant named above was enrolled in your institution: From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ 2. Was the applicant awarded a degree? Yes ☐ No ☐ • If yes, enter: Degree Received: _____ Date (mm/dd/yyyy) Degree Conferred: _____ • If no, attach explanation of reason applicant did not receive a degree.
AFFIX INSTITUTION OR NOTARY SEAL HERE	**I certify that the information above is an accurate account of the applicant's records and is true and correct.** **Printed Name of Institution Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Council office at the address above.**